



NATIONAL ASSOCIATION OF DEVELOPMENTAL DISABILITIES COUNCILS

ALERT

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#100-33
October 11, 1988

Information Alert:
Medicaid Reform
House Hearing

TO: DD Council Executive Directors
FROM: Susan Ames-Zierman

On September 30, 1988, Congressman Henry Waxman held a hearing on his bill, H.R. 5233, and that of Congressman Florio, H.R. 3454, which is the House companion bill to Senator Chafee's S. 1673, the Medicaid Home and Community Quality Services Act. Mr. Waxman's opening statement is enclosed.

Attached is testimony given by Congressman Steve Bartlett of Texas, Senator Chafee, and the Congressional Budget Office. Also enclosed is a side-by-side comparison of the two bills and current Medicaid law developed by the Congressional Research Service of the Library of Congress..

Senator Bentsen has agreed to mark up Senator Chafee's bill early in the 101st Congress. Should Senator Bentsen become the Vice-President, Senator Matsunaga of Hawaii would become Senate Finance Committee Chairman and would, in all likelihood, be agreeable to moving forward. Congressman Waxman, while not going as far as to discuss mark-up on either his or Florio's bill, did agree, in both his opening and closing statements, to work with Congressman Florio on a compromise early in the next Congress.

A list of current co-sponsors of the Chafee/Florio bills is attached. We need to keep all those returning Senators and Congressman on-board when this process begins anew in January. For those in your Congressional delegations who are not current co-sponsors, plan some visits to programs while they are home campaigning this fall and over the holidays. As Congressman Bartlett noted in his testimony, visits to an institution and a community facility make very important impressions on policy-makers. Keep the faith!

RECEIVED

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Minnesota D.D.
Council

"Medicaid Home and Community Quality Services Act of 1987"

Current Co-sponsors - September 27, 1988
S.1673 (48 co-sponsors) and H.R.3454 (200 co-sponsors)

ALABAMA

Sen. Richard Shelby (D)
Sen. Howell Heflin (D)
Rep. Tom Bevill (D) Rep.
Ben Erdreich (D) Rep.
Claude Harris (D)

ALASKA (full delegation)
Sen. Ted Stevens (R) Rep.
Frank Murkowski (R) Rep.
Don Young (R)

ARIZONA

Rep. John Rhodes (R)
Rep. Morris Udall (D)

ARKANSAS

Sen. David Pryor (D)*1

CALIFORNIA

Sen. Alan Cranston (D)
Rep. Tony Coelho (D) Rep.
Matthew Martinez (D) Rep.
Victor Fazio (D) Rep. Don
Edwards (D) Rep. Duncan
Hunter (R) Rep. Ronald
Dellums (D) Rep. Jim Bates
(D)**(2) ; . Tom Lantos
(D) . f. Ron Packard (R)
Rep. Nancy Pelosi (D) Rep.
Barbara Boxer (D)

COLORADO

Sen. William Armstrong (R)*
Sen. Timothy Wirth (D)
Rep. Hank Brown (R)
Rep. Ben Nighthorse Campbell (D)
Rep. David Skaggs (D)
Rep. Daniel Schaefer (R)**
Rep. Patricia Schroeder (D)

CONNECTICUT (full delegation)

Sen. Lowell Weicker (R) Sen.
Christopher Dodd (D) Rep.
John Rowland (R) Rep. Bruce
Morrison (D) Rep. Nancy
Johnson (R) Rep. Barbara
Kennelly (D) Rep. Christopher
Shays (R) Rep. Sam Gejdenson
(D)

DELAWARE

Sen. Joseph Biden (D)
Rep. Thomas Carper (D)

DISTRICT OF COLUMBIA (full delegation)

Del. Walter Fauntroy (D)

FLORIDA

Sen. Lawton Chiles (D)
F. Lawrence Smith (D)
Rep. Earl Hutto (D)
Rep. Connie Mack (R)
Rep. Bill Grant (D)
Rep. William Lehman (D)
Rep. Claude Pepper (D)
Rep. Bill Nelson (D)

GEORGIA

Sen. Sam Nunn (D)
Sen. Wyche Fowler, Jr. (D)
Rep. Charles Hatcher (D)
Rep. J. Roy Rowland (D)
Rep. George Darden (D)
Rep. John Lewis (D)
Rep. Robert Lindsay Thomas (D)
Rep. Ed Jenkins (D)

HAWAII (full delegation)

Sen. Daniel Inouye (D) Sen.
Spark Matsunaga (D)* Rep.
David Akaka (D) Rep.
Patricia Saiki (R)

IDAHO

Rep. Richard Stallings (D)

ILLINOIS

Rep. Cardiss Collins (D)**(2)
Rep. Charles Hayes (D)
Rep. Kenneth Gray (D)
Rep. Jack Davis (R)
Rep. Sidney Yates (D)
Rep. Lane Evans (D)
Rep. Jerry Costello (D)

INDIANA

Rep. Lee Hamilton (D)
Rep. Jim Jontz (D)
Rep. Peter Visclosky (D)
Rep. Andrew Jacobs (D)
Rep. Frank McCloskey (D)

IOWA

Sen. Tom Harkin (D)
Rep. Dave Nagle (D)
Rep. Neal Smith (D)

KANSAS

Sen. Robert Dole (R)*(1)
Rep. Dan Glickman (D)
Rep. Jan Meyers (R)

KENTUCKY

Rep. Carroll Hubbard, Jr. (D)

LOUISIANA

MAINE

Sen. George Mitchell (D)*(1)
Rep. Olympia Snowe (R) Rep.
Joseph Brennan (D)

MARYLAND (full delegation)

Sen. Paul Sarbanes (D) Sen. Barbara
Mikulski (D) Rep. Kweisi Mfume
(D) Rep. Benjamin Cardin (D)
Rep. Steny Hoyer (D) Rep.
Constance Morella (R) Rep.
Helen Bentley (R) Rep. Roy
Dyson (D) Rep. Beverly Byron
(D) Rep. Thomas McMillen (D)

MASSACHUSETTS

Sen. John F. Kerry (D)
Rep. Nicholas Mavroules (D)
Rep. Brian Donnelly (D)
Rep. Joe Moakley (D)
Rep. Chester Atkins (D)
Rep. Gerry Studds (D)

MICHIGAN

Sen. Donald Riegle (D)*(1)
Rep. Paul Henry (R) Rep.
John Conyers (D) Rep.
George Crockett (D) Rep.
Guy Vander Jagt (R) Rep.
Fred Upton (R) Rep. Bill
Schuette (R) Rep. Howard
Wolpe (D) Rep. Robert Davis
(R) Rep. Dale Kildee (D)
Rep. William Ford (D) Rep.
Dennis Hertel (D) Rep.
William Broomfield (R) Rep.
Bob Traxler (D) Rep. Carl
Pursell (R) Rep. David
Bonior (D)

MINNESOTA

Rep. James Oberstar (D)
Rep. Martin Sabo (D)
Rep. Timothy Penny (D)
Rep. Arlan Stangeland (R)
Rep. Bruce Vento (D)

Rep. Gerry Sikorski (D)**(1)

MISSISSIPPI

MISSOURI

MONTANA

Sen. Max Baucus (D)*(1)
Rep. Pat Williams (D)
Rep. Ron Marlenee (R)

NEBRASKA

NEVADA

Sen. Chic Hecht (R)

NEW HAMPSHIRE

Sen. Gordon J. Humphrey [R]
Rep. Robert C. Smith (R)
Rep. Judd Gregg (R)

NEW JERSEY (full delegation)
Sen. Bill Bradley (D)*(1) Sen.
Frank Lautenberg (D) Rep. James
Florio (D)** Rep. Dean Gallo
(R) Rep. Robert Roe (D) Rep.
Bernard Dwyer (D) Rep. Peter
Rodino (D) Rep. James Courter
(R) Rep. William Hughes (D)
Rep. Matthew Rinaldo (R)**
Rep. Frank Guarini (D) Rep.
Robert Torricelli (D) Rep.
Christopher Smith (R) Rep.
Marge Roukema (R) Rep. Jim
Saxton (R)

NEW MEXICO
Sen. Jeff Bingaman (D)
Rep. Bill Richardson (D)**

NEW YORK

Sen. Daniel Moynihan (D)*
Rep. Ted Weiss (D)
Rep. Robert Garcia (D)
Rep. Charles Rangel (D)
Rep. George Wortley (R)
Rep. Benjamin Gilman (R)
Rep. Sherwood Boehlert (R)
Rep. Major Owens (D)
Rep. Edolphus Towns (D)
Rep. Robert Mrazek (D)
Rep. Thomas J. Manton (D)
Rep. Hamilton Fish (R)

NORTH CAROLINA Rep.
Walter Jones (D) Rep.
Alex McMillan (R) Rep.
David Price (D) Rep.
James Clarke (D)

NORTH DAKOTA (full delegation)
Sen. Kent Conrad (D) Sen.
Quentin Burdick (D) Rep. Byron
Dorgan (D)

OHIO
Rep. Tony P. Hall (D)
Rep. James A. Traficant (D)
Rep. Edward Feighan (D)
Rep. Mary Rose Oaker (D)
Rep. Marcy Kaptur (D)
Rep. Douglas Applegate (D)
Rep. Thomas Luken (D)**
Rep. Bob McEwen (R)
Rep. Donald Lukens (R)
Rep. Donald Pease (D)

OKLAHOMA

OREGON
Sen. Mark Hatfield (R)
Rep. Ron Wyden (D)**(2)
Rep. Peter DeFazio (D)
Rep. Les AuCoin (D)

PENNSYLVANIA Sen. Arlen Specter (R)
Rep. Joseph Kolter (D) Rep. Curt
Weldon (R) Rep. William Coyne (D) Rep.
Doug Walgren (D)**(2) Rep. Thomas
Ridge (R) Rep. Thomas Foglietta (D)
Rep. Peter Kostmayer (D) Rep. Gus
Yatron (D) Rep. Austin Murphy (D)

RHODE ISLAND (full delegation)
Sen. John Chafee (R)*(1) Sen.
Claiborne Pell (D) Rep. Fernand St.
Germain (D) Rep. Claudine Schneider
(R)

SOUTH CAROLINA (full delegation)
Sen. Ernest Hollings (D)
Sen. Strom Thurmond (R)
Rep. John Spratt (D)
Rep. Arthur Ravenel (R)
Rep. Elizabeth Patterson (D)
Rep. Robin Tallon (D)
Rep. Butler Derrick (D)
Rep. Floyd Spence (R)

SOUTH DAKOTA
Sen. Thomas Daschle (D)*
Rep. Tim Johnson (D)

TENNESSEE
Sen. Albert Gore (D) Rep. Jim Cooper
(D)** Rep. Marilyn Lloyd (D) Rep.
Harold Ford (D) Rep. Bob Clement (D)

TEXAS
Rep. Henry Gonzales (D) Rep.
Martin Frost (D) Rep. Beau
Boulter (R) Rep. Ron Coleman
(D) Rep. Albert Bustamonte
(D) Rep. Jim Chapman (D) Rep.
Charles Wilson (D) Rep. Steve
Bartlett (R) Rep. Solomon
Ortiz (D) Rep. Charles
Stenholm (D) Rep. John Bryant
(D)** Rep. Mickey Leland
(D)**(2) Rep. Kika de la
Garza (D) Rep. Richard Armey
(R) Rep. Marvin Leath (D)

UTAH (full delegation)
Sen. Orrin Hatch (R) Sen.
Jake Garn (R) Rep. Howard
Nielson (R)** Rep. Wayne
Owens (D) Rep. James
Hansen (R)

VERMONT (full delegation)
Sen. Patrick Leahy (D)
Sen. Robert Stafford (R)
Rep. James Jeffords (R)

VIRGINIA

Rep. Frank Wolf (R)

WASHINGTON

Sen. Brock Adams (D)
Sen. Daniel Evans (R)
Rep. Thomas Foley (D)
Rep. Norman Dicks (D)
Rep. Mike Lowry (D)
Rep. Don Bonker (D)
Rep. John R. Miller (R)

WEST VIRGINIA

Sen. John D. Rockefeller, IV (D)*3
Rep. Nick Rahall (D)
Rep. Harley Staggers (D)
Rep. Bob Wise (D)

WISCONSIN

Rep. Les Aspin (D)
Rep. Robert Kastenmeier (D)
Rep. Jim Moody (D)
Rep. Steven Gunderson (R)

WYOMING

Sen. Malcolm Wallop (R)*

•Member of Senate Finance Committee

* (1) Member of Subcommittee on Health

••Member of House Energy and Commerce Committee

?•(2) Member of Subcommittee on Health and the Environment

OPENING STATEMENT OF
THE HONORABLE HENRY A. WAXMAN, CHAIRMAN
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
ON
LEGISLATION TO IMPROVE THE MEDICAID PROGRAM
FOR THE MENTALLY RETARDED September
30, 1988

This morning the Subcommittee will hear testimony on two bills to improve the Medicaid program for the mentally retarded and developmentally disabled. One is a bill I've introduced, H.R. 5233; the other is a bill introduced by Representative Florio, H.R. 3454.

Let's begin with some facts. As it happens, today is the last day of fiscal year 1988. The Federal government will spend, this fiscal year, about \$30.4 billion in Medicaid payments for health care services for the poor. Over 10 percent of that amount, or \$3.5 billion, will pay for services to the roughly 151,000 disabled living in intermediate care facilities for the mentally retarded, often called ICFs/MR.

Many of these individuals are severely or profoundly retarded, and many are medically fragile. In short, this is an extremely vulnerable population. The average Federal Medicaid payment for these individuals is \$23,000 per year, more than 15 times the average per capita expenditure of \$1250 per year for all Medicaid beneficiaries.

There are over 3600 ICFs/MR, ranging in size from 4 beds

to 1,500 beds. In order to receive Medicaid payments, these facilities must, among other things, provide "active treatment"¹¹ to their clients. The Medicaid program does not generally pay for "active treatment" or related services, such as habilitation, outside of an ICF/MR.

The one exception to this is the home- and community-based services waiver, authored by this Subcommittee in 1981. Under this waiver, well over 30 States are providing habilitation and other community-based services to some 25,000 mentally retarded or developmentally disabled individuals in the community. The Federal expenditure this year for these waiver services will be about \$160 million, a small fraction of the \$3.5 billion we will have spent on ICF/MR care.

The large Medicaid investment in ICF/MR services, and the relatively small Medicaid investment in community-based services, has touched off a major debate among parents, client advocates, State officials, treatment professionals, workers, and others. It is that debate which brings us to today's hearing.

I am concerned that this debate, which has been focussed on the Florio bill, is divisive. I believe that all the parties to this debate share a common interest in improving the way Medicaid works for the disabled. I have introduced H.R. 5233, which takes a much different approach to this problem than does the Florio bill, in an effort to redirect the debate toward finding that common interest.

H.R. 5233 has two basic purposes: to increase the

availability of high-quality community-based services under Medicaid, and to improve the quality of institutional services paid for by the Medicaid program. It proposes a limited, incremental reform: the next logical expansion of coverage beyond the current waiver program. It has a price tag that I believe is reasonable in today's budget climate, and it is neutral on the question of large versus small facilities.

The purpose of today's hearing is to see whether, by comparing the Florio and Waxman bills, we can identify a middle ground on the question of Medicaid reform for the disabled. I am hopeful that out of this hearing will develop discussions that lead to a consensus on Medicaid reform that clients, parents, advocates, workers, and State officials can support. I would then hope that the Subcommittee could consider legislation on this issue early in the next Congress.

We will start off this hearing with statements from Senator Chafee, and Representative Bartlett, both of whom I am happy to welcome here. We will then be hearing from a Medicaid consumer, and from parents who have children living both in institutions and at home or in the community. The Congressional Budget Office will present cost estimates on both pieces of legislation, and finally we will hear about the impacts of both bills from the perspectives of the providers, the States, and the employees who work in institutions.

I would also like to note that Representative Florio, the lead sponsor on one of the bills before us today, was called out of town at the last minute and will not be able to join us

today. I want to acknowledge his leadership and commitment to improving **the way** the Medicaid program works for the disabled, and I look forward to working closely with him in the next Congress on moving legislation through the Congress.

I would also like to recognize my colleague from Utah, Mr. Nielson, who will be joining the Subcommittee today at this hearing.

The Congressional Research Service has prepared a side-by-side analysis of the two bills before us today. Without objection, I'd like to insert it in the record.

Before proceeding to our first panel, I would like to recognize the distinguished ranking minority member, Mr. Madigan, for any remarks he might wish to make.

TESTIMONY BY SENATOR
JOHN H. CHAFEE
BEFORE THE
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
SEPTEMBER 30, 1988

Mr. Chairman, I commend you for holding this hearing. I was pleased to learn of the introduction of your legislation, HR 5233, and am glad you are looking into the critical issue of expanding Medicaid services for those with disabilities.

We have worked together over the years on other important issues such as Medicaid expansions for pregnant women and children and Medicare improvements. I am certain that we will be able to join together to assure that all individuals with disabilities and their families have the services they currently lack.

I am here today to talk about H.R. 3454 and its companion bill in the Senate, S. 1673: the Medicaid home and Community Quality Services Act of 1987. To date, 48 members of the Senate have cosponsored this bill. Eleven are members of the Finance Committee which has jurisdiction in the Senate. In the House there are 201 cosponsors.

What does my legislation do?

As our understanding of the needs and capabilities of those with disabilities has progressed, it has become clear that the traditional medically oriented services provided through Medicaid are frequently inadequate. One can not truly treat a person's medical problems without also addressing his non-medical needs.

The goal of my proposal is simple: to address the full spectrum of needs of those with disabilities so that each person has the opportunity to pursue education, recreation and vocation to the best of his or her ability. ' /

My proposal would ensure that a wide range of services and support for those with disabilities would be available in a variety of residential settings -- from in-home support such as respite and attendant care to institutionalization. It would mandate the provision of four critical services -- case management, individual and family support, protective intervention and specialized vocational services -- as well as expand the optional services now available through Medicaid. These services would be designed to meet each individual's needs rather than requiring an individual to "fit into" a service system or residential setting.

My proposal would also expand eligibility for these services. Currently, Medicaid services for those with disabilities are

limited to those who become disabled prior to the age of 22. My bill will phase-in those who become disabled after that age.

In order to ensure that states do develop a viable community based system of services, my bill would freeze federal funding for most facilities with over fifteen beds.

The Medicaid Home and Community Quality Services Act provides the mechanism to allow those with disabilities to live in the community with the security and support they need along with the opportunity to grow and develop as individuals. Just as important, it allows those who are currently living in the community – at home or in some other arrangement – to remain there by giving them and their families the services they need.

This proposal challenges the idea that long term care services must be medically oriented. Each person with a disability has a variety of medical needs which must be met. Just as important, however, is the quality of life of the individual and the recognition of his or her potential for growth and productivity.

Medicaid reform has been controversial. But I believe that the bill as currently written is a sensible response to a pressing need. This is reflected in the fact that it is cosponsored by close to a majority in both the Senate and, the House. I might point out

that in the Senate we have had four hearings on this bill and thus have the benefit of a great deal of discussion on this issue.

As many of you know this debate has been going on since 1983. Two previous bills I introduced were "deinstitutionalization" bills -- they would have eliminated all (or a substantial part of) federal funding for services provided in large institutional settings. We had hearings on these measures in the Finance Committee and I talked to countless individuals and organizations opposed to those bills. They convinced me that those bills went too far. They have won the battle. We have gone from zero funding to 100% funding.

The freeze in the current version of the bill is not a deinstitutionalization provision. Instead it is a provision designed to ensure that community based services will be developed and that those living in institutional settings are appropriately placed.

One common theme through all of the testimony and discussions I have had over the past five years is concern about the lack of community based services for those with physical and mental impairments. Disagreement arises when we begin to discuss how to expand and develop community based services in order to achieve a

system that truly represents a variety of choices for individuals needing services.

I hope this Committee will act on this bill early next year year. We have a committment from the Chairman of the Senate Finance Committee, Senator Bentsen, to have a mark-up early next year and I hope the House will follow suit. This is compromise legislation. It is the product of five years of discussions and a consensus of the vast majority of organizations representing those with developmental disabilities. It is time for Congress to move to accommodate the concerns and needs of the hundreds of thousands individuals and families who desperately need assistance and who want a true choice in how that assistance is provided.

Thank you Mr. Chairman. I look forward to an interesting and positive hearing. I hope it will lead us to action in the near future.

TESTIMONY BY CONGRESSMAN STEVE BARTLETT
BEFORE THE HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
SEPTEMBER 30, 1988

IT IS A PLEASURE TO APPEAR BEFORE THIS SUBCOMMITTEE TO EXPRESS MY SUPPORT FOR H.R. 3454, THE MEDICAID HOME AND COMMUNITY QUALITY SERVICES ACT. AS OF THIS WEEK, H.R. 3454 HAS 200 COSPONSORS IN THE HOUSE WHICH REPRESENTS BIPARTISAN AND WIDESPREAD SUPPORT FOR THIS BILL INTRODUCED BY CONGRESSMAN FLORIO.

H.R. 3454 WILL MAKE A SIGNIFICANT CONTRIBUTION TOWARD CONGRESS¹ GOAL OF ASSISTING PERSONS WITH DISABILITIES TO LIVE AS INDEPENDENTLY AS POSSIBLE IN COMMUNITY SETTINGS. I AM CONVINCED THAT THIS LEGISLATION PROVIDES OPPORTUNITIES TO THOSE DISABLED INDIVIDUALS WHO CHOOSE TO LIVE IN SUCH SETTINGS, WHILE RESPECTING THE CHOICE OF THOSE FAMILIES WHO PLACE THEIR DISABLED FAMILY MEMBER IN LARGE CONGREGATE RESIDENCES.

I RECOMMEND THAT THE MEMBERS OF CONGRESS, PARTICULARLY MEMBERS OF THIS SUBCOMMITTEE VISIT A STATE SCHOOL AND A GROUP HOME IN THEIR DISTRICT ONCE THE CONGRESS HAS ADJOURNED THIS FALL. I HAD AN OPPORTUNITY IN JULY TO VISIT THE DALLAS CONVALESCENT CENTER, A STATE SUPPORTED CENTER WITH 104 PROFOUNDLY MENTALLY RETARDED RESIDENTS. INDIVIDUALS RESIDING AT THE DALLAS CONVALESCENT CENTER HAVE AN IQ OF 35 OR BELOW AND ARE CONSIDERED LEVEL 6 IN THE ICF-MR SYSTEM, THE LOWEST LEVEL OF MENTAL RETARDATION FOR

ICF-MRS. THE CLIENTS WERE NON-AMBULATORY AND THE MAJORITY WERE INCONTINENT. THE PERSONNEL AT THE DALLAS CONVALESCENT CENTER INFORMED ME THAT NONE OF THEIR CLIENTS WOULD EVER BE CAPABLE OF LIVING IN A GROUB-HOME IN THE COMMUNITY OR SEEK EMPLOYMENT BECAUSE OF THEIR MULTIPLE DISABILITIES AND LEVEL OF MENTAL RETARDATION.

THAT SAME AFTERNOON I VISITED BETHPHAGE, A GROU? HOME PRIVATELY FUNDED BY THE EYANGELICAL LUTHERAN CHURCH WHERE 6 PROFOUNDLY RETARDED LEVEL 6 WOMEN RESIDE. THE MAJORITY OF THESE WOMEN WERE INCONTINENT AND NONAMBULATORY WHEN THEY ARRIVED AT THE GROUP HOME 6 MONTHS EARLIER FROM STATE SUPPORTED SCHOOLS. ALL WOMEN ARE NOW CONTINENT AND AMBULATORY. ONE WOMAN WHO HAD RESIDED IN A STATE SCHOOL FOR ALMOST 40 YEARS HAD ALWAYS BEEN NONAMBULATORY AND HAD NUMEROUS SEIZURES A DAY. IN JUST SIX MONTHS AT BETHPHAGE SHE HAD LEARNED HOW TO WALK, PUT HER WHEELCHAIR IN THE CLOSET AND HAD ONLY HAD ONE SEIZURE SINCE SHE HAD BEEN AT BETHPHAGE. IT WAS A MIRACLE TO SEE THESE LEVEL 6 PROFOUNDLY MENTALLY RETARDED CLIENTS BECOME SO INDEPENDENT IN A FEW MONTHS DUE TO THE SMALL HOME SETTING THAT GROUP HOMES PROVIDE.

WHILE THIS REPRESENTS MY OWN PERSONAL EXPERIENCE, THERE IS DATA AVAILABLE SPECIFICALLY FROM THE DEVELOPMENTAL DISABILITY CENTER AT TEMPLE UNIVERSITY WHICH HAS STUDIED THE PROGRESS OF PEOPLE COMING OUT OF INSTITUTIONS AND LIVING IN THE COMMUNITY. I URGE

THE MEMBERS OF THIS SUBCOMMITTEE TO STUDY THIS DATA AND TO WITNESS A SIMILAR EXPERIENCE BY VISITING A GROUP HOME AND INSTITUTION IN THEIR CONGRESSIONAL DISTRICT.

MY DECISION TO SUPPORT THIS LEGISLATION WAS NOT MADE LIGHTLY. I DECLINED TO COSPONSOR PREVIOUS VERSIONS THAT IMPOSED UNREALISTIC AND MANDATORY REDUCTIONS ON SUPPORT TO INSTITUTIONS; YET I AM DISSATISFIED WITH THE CURRENT SYSTEM OF MEDICAID support WHICH DOES NOT PROVIDE EQUITABLE SUPPORT TO SMALL COMMUNITY-BASED SETTINGS. CURRENT LAW IS SEVERELY BIASED TOWARD RESIDENTS LIVING IN AN APPROVED INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR). THE OVERWHELMING MAJORITY OF THESE ICF/MR APPROVED FACILITIES ARE LARGE INSTITUTIONS.

H.R. 3454 ELIMINATES THIS INEQUITY BY PLACING A CEILING ON FUNDING ICF/MR PROGRAMS AT CURRENT LEVELS. SUCH A CEILING WILL NOT THREATEN THE QUALITY OF SERVICES THAT ARE BEING PROVIDED TO PERSONS IN INSTITUTIONS BECAUSE THE NUMBER OF INDIVIDUALS PLACED IN INSTITUTIONAL SETTINGS IS GRADUALLY BEING REDUCED. THE EXPERIENCE IN MY STATE OF TEXAS IS A GOOD EXAMPLE OF THE INTERACTION BETWEEN THE CEILING, STATE POLICIES, AND THE SECURITY AND QUALITY OF SERVICES FOR INDIVIDUALS WHO WILL CONTINUE TO RESIDE IN INSTITUTIONS.

TEXAS IS CURRENTLY IN THE MIDDLE OF A SIX-YEAR STRATEGIC PLAN TO REDUCE THE SIZE OF ITS INSTITUTIONAL POPULATION. TWO YEARS AGO THE STATE HAD 10,000 PERSONS WITH DISABILITIES RESIDING IN INSTITUTIONS, LAST YEAR THAT POPULATION WAS REDUCED TO 8,200 AND THE TARGET FOR THE END OF 1988 IS 7,200. THE STATE IS ASSISTING IN THE PLACEMENT OF THOSE INDIVIDUALS WHO ARE MOVING OUT OF THE INSTITUTIONS AND INTO COMMUNITY SETTINGS. TEXAS HAS ENGAGED IN THIS PROCESS BECAUSE OF THE STATE'S BELIEF IN THE FINANCIAL AND PROGRAMMATIC BENEFITS OF COMMUNITY LIVING. WHILE THE STATE RECOGNIZES THAT THERE ARE THOSE INDIVIDUALS FOR WHOM AN INSTITUTIONAL SETTING WILL BE APPROPRIATE, THE TREND IS TOWARD CREATING INCREASED COMMUNITY-BASED PLACEMENTS. ALL GROWTH, IN FUNDING AND POPULATION, WILL THUS BE DRIVEN TO THE AREAS OF THE GREATEST NEED AND DEMAND: COMMUNITY-BASED RESIDENCES.

THE CEILING ALSO PLAYS A CONSTRUCTIVE ROLE IN CONTAINING COSTS. IN PRELIMINARY ESTIMATES, THE CONGRESSIONAL BUDGET OFFICE HAS INDICATED THAT IN THE INITIAL YEARS FOLLOWING ENACTMENT, THE BILL WILL RESULT IN NET SAVINGS DURING THE FIRST FIVE YEARS AND IN THE SIXTH, SEVENTH, AND EIGHTH YEARS THE BILL'S COSTS WILL BE APPROXIMATELY \$300 MILLION PER YEAR. THE INITIAL SAVINGS IS ATTRIBUTABLE TO THE CONTAINMENT THAT WILL BE PLACED ON THE CURRENT PROGRAM'S GROWTH RATE. I AM ANXIOUS, HOWEVER, TO HEAR CBO'S TESTIMONY TODAY ON THEIR OFFICIAL COST OF THIS LEGISLATION.

I AM CONVINCED THAT THE PROVISION OF QUALITY SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES WILL LEAD TO INCREASED FINANCIAL **AND** PERSONAL INDEPENDENCE, REGARDLESS OF THE SETTING. H.R. 34 54 WILL MAKE A SIGNIFICANT CONTRIBUTION IN HELPING DISABLED PEOPLE RECEIVE THE TRAINING AND ASSISTANCE THEY NEED TO GET A JOB AND LIVE INDEPENDENTLY OF FEDERAL FINANCIAL CASH ASSISTANCE. THE FEDERAL GOVERNMENT SPENDS BILLIONS OF DOLLARS EACH YEAR TOWARD THIS GOAL. OUR VOCATIONAL REHABILITATION AND SPECIAL EDUCATION SYSTEMS ARE ORIENTED TOWARD PLACING PERSONS IN THE COMMUNITY WITH THE SKILLS THEY NEED TO FUNCTION AND WORK INDEPENDENTLY. HOWEVER, THE CURRENT MEDICAID SYSTEM DOES NOT PROVIDE THE KIND OF COMMUNITY-BASED SERVICES THAT ARE NEEDED TO MAXIMIZE OUR SPECIAL EDUCATION AND REHABILITATION EFFORTS. BY MAKING MEDICAID FUNDS AVAILABLE TO SUPPORT COMMUNITY-BASED RESIDENCES, H.R. 34 54 WILL COMPLEMENT OTHER CONGRESSIONAL EFFORTS AIMED AT EMPLOYMENT AND INDEPENDENCE FOR PEOPLE WITH DISABILITIES.

I SUPPORT THIS LEGISLATION BUT I RECOGNIZE THAT THERE ARE CERTAIN ASPECTS OF THE BILL THAT NEED MORE WORK. I BELIEVE THESE HEARINGS WILL HELP US SORT OUT THOSE ANSWERS SO THAT WE CAN CONTINUE WORK ON THIS LEGISLATION DURING THE FALL AND DEVELOP A BILL THAT CAN PASS IN THE 101ST CONGRESS.

THANK YOU

Statement of
Charles E. Seagrave
Unit Chief Human
Resources Cost Estimates
Budget Analysis Division
Congressional Budget Office

before the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

September 30, 1988

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Friday, September 30, 1988.

Mr. Chairman, I am pleased to appear before this Committee to discuss the Congressional Budget Office's (CBO's) cost estimates of two bills-- H.R. 3454, the Medicaid Home and Community Quality Services Act of 1987 as introduced by Congressman Florio, and H.R. 5233. the Medicaid Quality Services to the Mentally Retarded Amendments of 1988 as introduced by Congressman Waxman. The federal cost estimates of both bills are shown in Table 1. Both bills are designed to increase the availability of home- and community-based services for certain disabled individuals by expanding the current services offered through the Medicaid program.

TABLE 1. ESTIMATED FEDERAL COSTS (By fiscal year, in millions of dollars)

	1989	1990	1991	1992	1993	Five-Year Totals 1989-1993
Increase in Recipients and Services						
Florio Bill	0	0	355	750	1140	2,245
Waxman Bill	0	25	25	30	35	115
Limitation on Payments to Institutions						
Florio Bill	0	-310	-640	-990	-1365	-3,305
Waxman Bill	0	0	0	0	0	0
Administrative and Personnel Costs						
Florio Bill	30	35	70	80	110	325
Waxman Bill	<u>1</u>	<u>6</u>	<u>7</u>	<u>10</u>	<u>13</u>	<u>37</u>
Total						
Florio Bill	30	-275	-215	-160	-115	-735
Waxman Bill	1	31	32	40	48	152

SOURCE: Congressional Budget Office.

My testimony today will cover four aspects of these bills:

- o The costs of the provisions in the Florio and Waxman bills that would increase recipients and services.
- o Some of the uncertainties inherent in these cost estimates.
- o The savings from a limitation on payments to certain institutions contained in the Florio bill; and
- o The costs of additional administrative responsibilities in the bills.

INCREASES IN RECIPIENTS AND SERVICES

Under current Medicaid law, states may not receive federal matching funds for providing home- and community-based services to the mentally retarded unless states are operating an optional targeted case management program, have been granted a 2176 waiver, or have opted to provide clinic, rehabilitation, and personal care services to the Medicaid population.

The Florio bill would require states to provide an array of community and family support services to any eligible individual with a severe disability. In addition, states at their option could cover any of 21 additional services. States would be required to offer the mandatory service package to eligible Medicaid individuals who have a severe disability and who live in a family home, foster family home, or community living facility. CBO estimates that

by 1993 an additional 115,000 persons would be served at a federal cost of \$1.1 billion under the Florio bill.

The Waxman bill would allow the states to offer community habilitation services on a statewide basis to people with mental retardation and related conditions. All additional services in the Waxman bill are optional to the states. In estimating the costs of these provisions, we have assumed that 15 percent of the states would provide these services. Approximately 15 percent of states currently provide coverage for optional services or optional groups. Based on this assumption, we estimate that an additional 3,500 people would be served at a federal cost of \$35 million under the Waxman bill in fiscal year 1993.

UNCERTAINTIES ASSOCIATED WITH THE ESTIMATES

CBO estimates that the Florio bill would add some \$1.1 billion in federal reimbursement for home- and community-based services by 1993- In contrast, the Waxman bill would add some \$35 million by 1993- Both bills, however, could increase costs by more or less than the estimates shown here.

In the case of the Florio bill, our estimates have been constrained by the potential growth over the five-year period in the supply of home and community services. As many as 115,000 persons are currently on waiting lists for home and community services. The industry has been growing at an annual rate of about 10 percent per year. CBO's estimate of the Florio bill assumes that supply would grow by no more than 70 percent per year. Were we to remove this constraint, our estimate of the costs of additional recipients and

services in the Florio bill would be \$1.3 billion in 1993. Even this assumption, however, does not represent the full costs of the bill because the participation rates for most groups covered by the bill would not reach stable levels until later in the decade. At full participation rates and with no constraint on supply, we estimate recipient and service costs would add \$2 billion per year by 1993-

In the case of the Waxman bill, we have assumed that 15 percent of the states would opt for the additional benefits. Based on Medicaid program data, approximately 15 percent of states today provide coverage for optional services or optional groups. In addition, recent federal legislation has increased Medicaid spending by states through a number of provisions including those that increase coverage for pregnant women and children and provide protection for spouses of institutionalized persons. Given the reluctance of states to pick up services that are at state option today, and given the increased requirements on states, it is unlikely that all states would carry the provisions of the Waxman bill. Nevertheless, if all states were to provide the additional benefits included in the Waxman bill, CBO's estimate of the 1993 costs would rise to about \$220 million and some 23,000 additional persons would receive benefits. At full participation rates for persons and states, estimated 1993 costs would be \$480 million and some 52,500 additional persons would receive benefits.

LIMITATION ON PAYMENTS TO INSTITUTIONS

By providing additional home- and community-based services, both bills provide incentives to avoid institutionalization for certain disabled people. The Florio bill further increases the incentives to move individuals from institutions back into the community by limiting the federal Medicaid matching payments to each state for services provided to any disabled individual under age 65 residing in skilled nursing facilities, intermediate care facilities, or intermediate care facilities for the mentally retarded. It would limit these payments to the amounts paid in a previous year. If the Florio bill were enacted this year, for example, federal payments to states for these activities for 1990 and beyond would be limited to their 1989 level.

CBO estimates that in 1990 this limitation would result in federal savings of \$310 million, growing to \$1.4 billion by 1993- These savings result from an assumption that payments would grow by more than 11 percent a year under current law. The actual growth between 1986 and 1987 was slightly over 11 percent.

States would face a difficult trade-off given the magnitude of the estimated reductions. States could either pick up a larger share of the costs themselves or they could reduce the costs of institutionalized care. CBO's estimate assumes that states would absorb one-half of the reduction in federal payments.

INCREASES IN ADMINISTRATIVE RESPONSIBILITY

Both bills would require federal, state, and local governments to share additional administrative responsibilities and to provide additional protection to employees who might be dislocated as a result of changes made by the bills.

The Florio bill would increase state responsibilities, particularly in the areas of quality assurance and client assessment. Based on Medicaid administrative data, CBO estimates that the average state would have to hire 20 people in the first two years and 60 people thereafter to meet the administrative requirements of the bill. The federal share of these administrative costs is estimated to grow from \$30 million in 1989 to \$110 million in 1993.

The Waxman bill also contains additional administrative responsibilities. For example, the Waxman bill would require the federal government to develop instruments and methods for evaluating and assuring the quality of community habilitation services. Moreover, it would require the states to use these instruments and methods in judging the quality of their community services. We estimate that the additional federal costs of the administrative responsibilities and personnel protection in the Waxman bill would be \$1 million in 1989, growing to \$13 million in 1993-



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September 27, 1988

TO : House Subcommittee on Health and the Environment
Attention: Andy Schneider

FROM : Mary F. Smith
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Side-by-Side Bill Comparison

As you requested, we have prepared a side-by-side comparison of H.R. 5233 and H.R. 3454, bills to expand Medicaid services to community-based persons with mental retardation or related conditions. This document was prepared by the Congressional Research Service in collaboration with your office. Current law is compared with the major provisions of H.R. 5233, introduced by Representative Waxman on August 11, 1988, and H.R. 3454, introduced by Representative Florio on October 8, 1987.

Community—Based. Services

States may not *currently* receive Federal Medicaid matching funds for providing home or community-based services to the mentally retarded, with certain exceptions. Under the case management option, States may target case management services on particular groups in designated areas within the State. Under the "2176" waiver, the Secretary of Health and Human Services (HHS) may authorize the payment of federal-Medicaid funds to States to provide habilitation and other community-based services to mentally retarded and persons with related conditions on a budget-neutral basis. To qualify for waived services individuals must show that, but for the waived services, they would need the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR),

Community-Based Services

Would give States the option of providing "community habilitation services" to persons with mental retardation and related conditions on a statewide basis. States would receive Federal Medicaid matching funds at their regular rates. This optional benefit would include self-help, socialization, and adaptive skills needed for community living; and prevocational, education, and supported employment services not available through other federal programs. The cost of room and board would be excluded. Services delivered in a supervised residential setting would be required to meet Federal standards, and States would be required to assure that specified protections were in place for employees affected by coverage of this service. (Section 101(a))

Community-Based Services

Would require States to provide "an array of community and family support Services" to any eligible individual with a severe disability, Including case management, individual and family support *IstTietli* specialized vocational services (including supported employment), and protective intervention. Would authorize States to cover, at their option, any of 21 additional categories Of community and family support services, including services provided by family members. With respect to both sandatory and optional services, Federal Medicaid matching funds would be available at regular rates. The cost of room and board provided for more than 12 weeks in any one year would be excluded. States could provide these new mandatory or optional services on less than a statewide basis for one 3-year period. (Sections 3 and 11).

Community-Based Services—
Continued

Waivers need not be statewide. (Section 1915(c) of the Social Security Act). Some States have used certain optional service categories. Including clinic services "other rehabilitation services," and personal care services, as a means of offering home and community-based services to this population. (Section 1905(a)(9), (13), and (21)).

Current Law

H.R. 5233
(Waxman)

H.R. 3454 (Florio)

Eligibility for
Community-Based
Services

To qualify for Medicaid, an individual must be disabled, as determined under the Supplemental Security Income (SSI) program (except in certain States using more restrictive standards) and must meet State income and resource standards. Persons with mental retardation or a related condition may qualify for services in an ICF/MR. Generally, for individuals who reside at home the income and resources of parents are "deemed" available to them for purpose of determining eligibility for Medicaid. The income and resources of parent* are not deemed available to individuals in Institutions such as ICF/MR. However, States may, at their option, cover individuals in the community who would be eligible if they were in an institution and who are receiving services under a "2176" waiver. (Section 1902(a)(10)(A)(ii)(IV))

Eligibility for Community-
Based Services

States could, at their option, cover "community habilitation services" for persons with mental retardation or a related condition if the individual (1) would be eligible for Medicaid in an institution and (2) would, but for the provision of "community habilitation services, require the level of care provided in an institution. "Persons with, a related condition" would, be defined as under current regulations. (Section 101(d)).

Eligibility for
Community-Based Service's

states would be required to offer "community and family support services" to "Individuals with a severe disability" eligible for Medicaid who live in a family home, foster family home, or community living facility. "Individuals with a severe disability" are defined as letting the disability definition under the SSI program, subject to specific age limits for the onset of the disability. The age of onset limitation would begin at age 22 and increase by one year each year to age 50. (Section 2), States would be required to continue Medicaid coverage for such individual* as long as they receive SSI benefits or are deemed to receive such benefits. (Section 10),

Current Law

H.R. 5233 (Waxman)

H.R. 3454 (Florio)

**Eligibility for Community-
Based Services—
Continued**

States that establish higher income eligibility standards for individuals in institutions would be required to apply those same standards to individuals in the community. (Section 8(c)). In addition, States would have the option of covering disabled children age 18 and under without regard to resources and without regard to the medically needy income limits. (Section 8).

CRS/L

Current Law

H.R. 5233 (Waxman)

H.R. 3454 (Florio)

Eligible Residences

No comparable provision.

Eligible Residences

no comparable provision.

Eligible Residences

Persons eligible for "community and family support services" would be required to live in family homes; foster homes (housing not more than three disabled Individuals); or community living facilities generally defined as a household in which the number of disabled persons did not exceed these times average family size. (Section 2).

CRS-6

Current Law**H.R. 5233 (Waxman)****H.R. 3454 (Florio)**

**Quality Assurance for
Community-Based Services**

Generally States must assure that payment for any Medicaid services are "consistent with quality of care." (Section 1902(a)(30)). States providing home find Community-based services covered under a "2176" waiver Are required to assure that necessary safeguards are in place to protect the health and welfare of beneficiaries. (Section 1915(c)).

**Quality Assurance for
Community-Based Services**

Would require the Secretary of HHS to develop outcome-oriented instruments and methods for evaluating and assuring the quality of "community habilitation services." Effective July 1, 1991, States would be required to use these instruments and methods, and no federal payments would be available for substandard services. (Section 103).

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**Quality Assurance for
Community-Based Services**

Would require States to establish a quality assurance system, including the promulgation of Standards for "community and family support services." The Secretary would be prohibited from promulgating such standards. States would certify or license all facilities and programs providing "community and family support services." The Secretary would annually assess the adequacy of the quality assurance components established by each state under its implementation strategy. (Section 11),

Current Law

H.R. 5233 (Waxman)

H.R. 3454 (Florio)

Payment for Community-Based
Services

Generally, States have discretion in setting payment rates, but payments must be "consistent with efficiency, economy, and quality of care." (Section 1902(a)(30)) .

Payment for community-Based
Services

Payments for "community habilitation services" would be required to be reasonable and adequate to meet the costs of providing the services In conformity with State and Federal laws, regulations, and quality and safety standards. (Section 401) .

Payment for Community-Based
Services

Payments for "community and family support services" would be required to be reasonable and adequate to assure the provision of care and services in conformity with state and Federal LAWS, regulations, and quality and safety standards, and to assure that Individuals with a severe disability have reasonable access to services of adequate quality. (Section 7) .

**Quality Of Institutional
Services**

States have the option Of covering services in an ICF/MR. Currently, 49 States cover ICF/MR services, serving over 154,000 Individuals with mental retardation or related conditions in over 3,600 ICFs./MR. that range in size from 4 to 1,500 beds. ICFs/MR must meet conditions of participation set forth by the Secretary of HHS in regulation? these were recently revised for the first time since 1974. (S3 Fed. Reg. 20443, June 3, 1988);

**Quality of Institutional
services**

Would redefine an ICF/MR as an "habilitation facility," an institution that primarily provides health or habilitation service*, including continuous active treatment, to persons with mental retardation or related conditions, and is not primarily for the care of persons with mental diseases. Requirements for participation would be set forth in statute, including requirements relating to provision of services, clients' rights, administration, and other matters. (Section 201).

**Quality of Institutional
Services**

No comparable provision.

Survey and Certification
Process for Institutional

States are responsible for surveying and certifying compliance by ICFs/MR with the conditions of participation. The Secretary has the authority to validate State survey and certification findings through "look behind" surveys. (Sections 1902(a)(33) (B) , 1910(b)). ICFs/MR are Subject to annual inspections of care and all admissions are subject to physician certification and re-certification. [Sections 1902(a)(31), (44), and 1903(g) .

Survey and Certification
Process for Institutional
Services

States would be responsible for surveying and certifying compliance by habilitation facilities with the requirements for participation, except those facilities operated by the State. The Secretary would be responsible for (1) validating, through "look-behind" surveys, state survey and certification activities, and (2) surveying and certifying State-operated facilities. Both State and Federal surveys would be based on a protocol developed by the Secretary. (Section 202). Upon implementation Of annual surveys under this section. the current inspection of care and physician certification requirements would be repealed. (Section 302).

Survey. and Certification
Process for Institutional
Services

The Secretary would lake changes in Federal regulations as were necessary to improve the reliability and consistency of survey findings and certification decisions. (Section 11).

Enforcement of institutional Requirements

Only certain remedies are Available to the Secretary in the event of non-compliance by an ICF/MR with the conditions of participation: (i) termination of all Medicaid payments to the facility (Section 1910(b)), (2) upon application by the state, implementation of a correction plan under which all staffing and plant deficiencies are corrected within 6 months, or (3) upon application by the State, implementation of a reduction plan under which a facility (with deficiencies that do not immediately jeopardize the health or safety of its clients) may permanently reduce the number of certified beds over a 3-year period while continuing to receive Federal Medicaid matching funds. The Secretary may not approve more than 15 correction or reduction plans in any 1 year and may not approve any such plans after April 6, 1989. (Section 1922).

Enforcement of Institutional Requirements

Would specify the enforcement actions to be taken by a State upon a finding of non-compliance; the actions would vary with whether or not the deficiencies immediately jeopardized the health and safety of the facility's clients. Would require States to establish by law or regulation the following remedies for non-compliance: (1) denial of payment for new admissions; (2) civil, money penalties with interest; (3) appointment of temporary management; and (4) emergency closure and transfer authority. Would mandate certain remedies in the event of repeated non-compliance. would authorize the Secretary to impose termination *and/or* a range of Intermediate sanctions to cure non-compliance. including (1) denial of payment for new admissions (2) civil money penalties up to \$10,000 per day of non-compliance, and

Enforcement of Institutional Requirements

would delete the current limitations on the Secretary's authority to approve more than 15 correction or reduction plans in any given year, and to approve any such plans within 3 years after the effective date of final regulations. (Section 9).

Current Law

H.R. 5233 (Waxman)

H.R. 3454 (Florio)

Enforcement of Institutional
Requirements—Continued

(3) appointment of temporary management. Would limit the current reduction plan authority to facilities with physical plant deficiencies and would repeal current numerical limitations regarding reductions plans. (Section 202).

**Payment for institutional
Service***

States electing to offer *ICF/HR* services are entitled to Federal Medicaid matching payments at the regular matching rate (varies from 50 to 78 percent, depending on State per capita income). (Section 1903(a)), States have discretion in setting payment rates for individual ICFs/MR; the Secretary, by regulation, has limited aggregate Medicaid payments for ICF/MR services in each State, and aggregate payments to State operated ICFs/MR in each State, to the estimated amount that would have been paid under Medicare reimbursement principles. (42 C.F.R. 447.272) The Medicare program does not cover ICF/HR services.

**Payment for Institutional
Services**

The Secretary would be prohibited from imposing any upper limit on Medicaid payments made for "community habilitation services" or for habilitation facility services. (Section 401).

**Payment for Institutional
Services**

Would limit Federal Medicaid matching payments to each State for services provided to any disabled individual under age 65 residing in skilled nursing facilities (SNFs), intermediate care facilities (ICFs), or ICFs/MR with 16 beds or more, to the amount: received by the State for such service for the fiscal year ending after the date of enactment. An exception to this matching payment ceiling would be made (1) to the extent that the increase in the consumer price index in any given year exceeds 6 percent and (2) to accommodate the costs of implementing ICF/MR reduction plans. (Section 4).

Current Law

H.R. 5233 (Waxman)

H.R. 3454 (Florio)

State Maintenance of Effort

No comparable provision.

State Maintenance of Effort

No comparable provision.

State Maintenance of Effort

State and local expenditures

from non-Federal funds for "community and family support services would be required to equal the amount of State and local expenditures for such services during fiscal year 1987, adjusted for inflation by the consumer price index, (Section 3).

Employee Protections

Any ICF/MR reduction plan must provide for the protection of the interests of affected employees, including training and retraining where necessary, redeployment to community settings and maximum efforts to guarantee employment. {Section 1922(c)(7)).

Employee Protections

States electing to cover "community habilitation services" or seeding approval of a reduction plan for a habilitation facility would be required to make specified arrangements to protect the interests of affected public or private employees, including (1) preservation of rights under collective bargaining agreements, (2) protections against a worsening of employment positions, (3) assurance of employment for facility employees at the same pay and level of responsibilities, (4) paid training and retraining for employment in "community habilitation services;" and (5) a grievance procedure meeting certain requirement a, (Section 501),

Employee Protections

States would be required to assure fair and equitable provisions to protect the interests of public employees affected by a transfer of individuals with a severe disability from public institutions to community or family living facilities under the State implementation strategy, including (1) maximum efforts to provide for employment, (2) arrangements to preserve employee rights and benefits, and (3) training and retraining of such employees where necessary. States would also be required to Apply fair employment standards and equitable compensation to workers in private programs and facilities participating in Medicaid. (Section 3).

**Preadmission Screening
and Client Review**

Effective January 1, 1989, States must have in effect a preadmission screening program with respect to all mentally retarded individuals entering general nursing facilities (SNFs and ICFs other than ICFs/MR) to determine, using minimum criteria developed by the Secretary, whether or not the individual requires the level of care provided by the nursing facility, and whether the individual requires active treatment for mental retardation. States are also required, as of April 1, 1990, to review and make the same Determinations with respect to each mentally retarded nursing facility resident. (Section 1902(e)(7))

**Preadmission Screening
and Client Review**

Effective October 1, 1999, States would be required to have in effect a preadmission screening program for mentally retarded individuals admitted to habilitation facilities to determine, using minimum criteria developed by the Secretary, whether or not the client requires the level of services provided by a habilitation facility and whether or not the client requires "community habilitation services." States are also required, as of October 1, 1990* to review and make the same determinations with respect to clients in habilitation facilities. (Section 30.).

**Preadmission Screening
and Client Review**

States would be required to assure that the needs of each individual admitted to an ICF/MR are ascertained by an interdisciplinary team within 30 days, including an assessment of the individual's needs for community and family support services. This

provision would take effect within 18 months after the date community and family support services were first covered under a State Medicaid plan, (Section 3},

Current Law

H.R. 5233 (Waxman)

H.R. 3454 (Florio)

State Implementation Strategy

No comparable provision.

State Implementation Strategy

No comparable provision.

State Implementation Strategy

would require States to establish and implement a 5-year State implementation, strategy that set forth a schedule for (1) expanding and improving community and family support services for individuals with a severe disability, And (2) transferring individuals with a severe disability from an ICF/MR with more than 15 beds to more appropriate residential settings. (Section 3).

Current Law**H.R. 5233 (Waxman)****H.R. 3454 (Florio)**

Protection and Advocacy

Under Part C of the Developmental Disabilities Assistance and Bill of Rights Act, the Secretary of BBS makes grants to States to support a system to protect the legal and button lights of persons with developmental disabilities, In both community and institutional settings. The FY 89 authorization is \$22 million.

Protect ion and Advocacy

NO comparable provision.

Protection and Advocacy

States would be required to have in effect a system to protect and advocate the rights of individuals with a severe disability who are eligible for Medicaid, States could use existing agencies funded under the Developmental Disabilities. Act. State expenditures for these protection and advocacy activities would be eligible for Federal matching payments At the regular State matching rates, (Section 5).

Current Law

H.R. 5233 (Waxman)

H.R. 3454 (Florio)

Private Right of Action

No comparable provision.

Private Right of Act ion

no comparable provision.

Private Right of Action

Would give any individual adversely affected or aggrieved by a violation of this Act the right to seek an injunction in Federal district court to enjoin such a violation by the State Medicaid agency. Prevailing plaintiffs would be allowed to recover attorneys' Fees and court costs. from the State defendant. (Section 6).

Administration

Medicaid is administered at the Federal level by the Secretary of HHS through the Health Care Financing Administration (HCFA) and at the State level by a single State agency designated by the State. (Section

Administration

State agencies administering programs for persons with developmental disabilities could be assigned by the State specific management functions relating to services for mentally retarded individuals. (Section 502).

Administration

The Secretary of HHS would be required to establish a Bureau of Developmental Disabilities within HCFA to administer the Medicaid program as it affects individuals with a severe disability. (Section 11).